## Health Certification Project MEDICATION PASS RECORD

## **DIRECTIONS:**

- Medication passes must be evaluated by an R.N., L.P.N., or Pharmacist C.M.A.'s <u>may not</u> evaluate medication passes for students.
- Medication passes on this record must be evaluated <u>after</u> the student has completed a minimum of 40 hours of training through an OSDH-Approved Program

• Students must pass medications to 20 consecutive individuals with 100% accuracy. All questions for all medications administered during a medication pass must be answered "Yes". For all "No" responses, the evaluator must explain the error(s) that occurred on the last page.

Facility Where Med Passes Were Performed:						City	City Where Facility is Located:							
Student Name: Eva			Evaluator's Name/Signature:									Result: PASS		FAIL
Actual Date/Time Medication Passed	Client Identifier *do not use full patient name	Dosag	Name of Drug, Dosage of Drug, and Form of Drug Passed		Was client identification verified?		Was correct drug passed?		Was drug dosage correct?		Was the correct form of the drug passed?		s the passed nd nented etly on MAR?	I observed this medication pass. (Evaluator's Initials)
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	
				Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	

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**Student Name:** Was the I observed drug passed this Was the Date/Time Name of Drug, Was client Was correct Was drug **Client Identifier** correct form medication and Dosage of Drug, Medication identification drug dosage \*do not use full patient of the drug documented pass. and Form of Drug Passed **Passed** name verified? passed? correct? correctly on (Evaluator's passed? the MAR? Initials) Yes Yes No Yes Yes Yes No No No No Yes Yes Yes Yes No No No No Yes No Yes Yes Yes No Yes Yes No No No No Yes No Yes No Yes No Yes No Yes No Yes Yes Yes Yes Yes No No No No No Yes Yes Yes Yes Yes No No No No No Yes Yes Yes Yes No No Yes No No No Yes No Yes No Yes No Yes No Yes No Yes Yes No Yes No Yes No No Yes No Yes No Yes Yes No Yes Yes No No No Yes No Yes No Yes No Yes No Yes No Yes Yes Yes Yes Yes No No No No No Yes Yes No Yes Yes Yes No No No No Yes Yes No Yes Yes Yes No No No No Yes No Yes No Yes No Yes Yes No No Yes No Yes No Yes No Yes No Yes No

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**Student Name:** Was the I observed Was the drug passed this Name of Drug, Date/Time Was client Was correct Was drug Client Identifier correct form and medication Dosage of Drug, drug dosage Medication identification \*do not use full patient of the drug documented pass. and Form of Drug Passed verified? **Passed** name passed? correct? correctly on (Evaluator's passed? the MAR? Initials) Yes Yes Yes Yes Yes No No No No No Yes Yes Yes Yes Yes No No No No No Yes Yes No Yes No Yes No No Yes No Yes Yes No No Yes Yes No Yes Yes Yes No No No No Yes Yes Yes Yes Yes No No No No No Yes Yes Yes Yes Yes No No No No No Yes Yes No Yes No Yes No Yes No No Yes Yes No Yes No Yes Yes No No No Yes No Yes No Yes No Yes No Yes No Yes Yes No Yes No Yes No Yes No No Yes Yes Yes No Yes No Yes No No No Yes Yes Yes Yes Yes No No No No No Yes Yes Yes Yes Yes No No No No No Yes No Yes No Yes No Yes No Yes No

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Student Name:								
Documentation of	Errors Observed	on Medication Passes						
Date/Time of Medication Pass	Client Identifier	Name of Medication Passed Incorrectly	Describe the error(s) made by the student:	Describe action taken:				

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